

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |   |  |  |                            |
|--|---|--|--|---|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>155029</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                            |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R-C</b><br><b>02/22/2016</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>COMMUNITY NURSING AND REHABILITATION CENTER</b> |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5600 E 16TH ST</b><br><b>INDIANAPOLIS, IN 46218</b> |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |  |  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
| {F 000}  | <p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00189842 completed on January 20, 2016.</p> <p>This visit was in conjunction with a PSR to the PSR completed on January 20, 2016, to the Recertification and State Licensure Survey completed on December 21, 2015.</p> <p>Complaint IN00189842 - Corrected</p> <p>Survey dates: February 22, 2016.</p> <p>Facility number: 000012<br/>Provider number: 155029<br/>AIM number: 100274900</p> <p>Census and bed type:<br/>SNF/NF: 89<br/>Total: 89</p> <p>Census and Payor type:<br/>Medicare: 12<br/>Medicaid: 53<br/>Other: 24<br/>Total: 89</p> <p>Community Nursing Rehabilitation was found to be in compliance with 410 IAC 16.2-3.1 in regard to the PSR of the Investigation of Complaint # IN00189842.</p> <p>Quality review completed by 30576 on February 23, 2016.</p> |  |  | {F 000}   |  |  |                            |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.